<講演会>「アメリカの高齢者介護」21世紀におけるケアの展望を構築する

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「アメリカの高齢者介護」

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Long-Term Care Policy for Older Americans : Developing a Continuum of Care in the Twenty-first Century

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Abstract

This essay deals primarily with social policy considerations relevant to the development of long-term care policy for the frail elderly in the United States. However, it also includes some commentary on meeting the acute care needs of the frail elderly. It defines chronic care treatment as a mix of "short-term" and "long-term" modes of care. Furthermore, it explores the need for treatment of such long-term illnesses to recognize the importance of alternative modes of caring which include strategies, both medical and non-medical, delivered within and outside of hospitals and nursing homes.

The essay includes an analysis of public and private sector priorities based in data published by the U.S. Centers for Medicare & Medicaid Services (formerly the U.S. Health Care Financing Administration). It also includes some discussion of the PACE Program in the United States and some other efforts to stimulate more in-home and community-based alternatives to nursing home care. Furthermore, it includes a discussion of the policy goal of "appropriateness" in developing long-term care (as well as general health priorities) and provides a critical discussion of problems with utilizing "cost benefit analysis." The study concludes that too exclusive a focus on nursing home care for the elderly in the United States is unfortunate — both in terms of the desires of the elderly, their families and friends and in terms of focusing on "appropriateness" as a legitimate policy goal in the development of long-term care policy for the elderly in the United States.

Introduction

This essay reviews current public policy regarding long-term care for the elderly in the United States. It examines public expenditure levels for long-term care. It advocates a better developed "continuum of care" with a greater emphasis on community-based care and in-home care services. In so doing it discusses

some innovative programs developed in the United States, particularly the Program for All Inclusive Care for the Elderly and some Section 1115 Medicaid Waiver Programs which place greater emphasis on the development of in-home and community-based services.

This essay also presents a case for the public policy goal of "appropriateness" or a goal of seeking "the least restrictive environment" compatible with providing services for a chronic condition as preferable to a public policy emphasis on cost/benefit analysis — which claims objectivity but often incorporates a variety of normative assumptions dressed up in numerical form.

Long-Term Care in the United States: Some General Comments

In 2000, 12.4 percent of the United States population of 281,422,000 were age 65 or over (or 34,992,000 persons). 18,391,000 persons were age 65 through 74 (or 6.5 percent of the population). 16,601,000 were 75 years of age and over or almost 6 percent of the population (U.S. Census Bureau, 2001).

As has been noted, this essay will deal primarily with the long-term chronic care needs of the frail elderly in the United States. However, it will also include some commentary on the acute care needs of the elderly in the United States. The definition of long-term care includes health and social care. Such care may be required as a consequence of impairments of an individual's ability to sustain the usual activities of daily life (which include eating, dressing, grooming, toileting, ambulating, and mobility and transfer) or from an uncertain diagnosis that depends upon the trajectory of the illness and the match between the resources needed in the physical environment and the resources which can be made available in a timely manner. As there is little expectation that the illness or cause of the disability will disappear — the illness is characterized as "chronic."

In reality chronic care treatment is often a mix of "short term" and "long term" modes of care (Koff, 1994). Also, there is a need in treatment of such long-term illnesses to recognize the importance of alternative modes of caring along "a continuum of care" which include strategies, both medical and nonmedical, delivered within and outside of hospitals.

Long-Term Care and Public Sector Spending: Some Initial Comments

In spite of much discussion and encouragement of community-based care, most of the public sector expenditures for long-term care services in the United States have been for institutional care — primarily for nursing home care and primarily through the means-tested Medicaid program.

According to the National Nursing Home Survey of 1995, elderly nursing home residents were primarily women (75 percent), 75 years of age and over (82 percent), white(89 percent), non Hispanic white (92 percent) and widowed (66 percent) (Dey, 1997). The average age of such elderly residents at the time of admission was 82 years, women were more likely to be older (83 years) than men (80 years) (Dey, 1997).

While we lack a clear picture of the socio/economic status of nursing home residents, at the time of admission , 38 percent of nursing home residents relied on the means-tested Medicaid program. Of those whose initial entry was on Medicare, 40 percent shifted to Medicaid by the month before they were interviewed by the National Nursing Home Survey. For those who were initially primarily on their own resources when they entered a nursing home, 22 percent had shifted to Medicaid as their primary funder (Dey, 1997).

In 1999, about one-half of all chronic care national personal health expenditures were financed directly by the elderly and their families. A substantial proportion of the other half of such costs was borne by the Medicaid program. Also, most of Medicaid personal health expenditures (over 62.5 percent) goes for institutional care — that is hospital care ($66.5 billion or 38 percent of Medicaid expenditures) or nursing home care ($42.4 billion or over 24 percent of Medicaid expenditures) (Cowan, et al., 2000).

A problem with Medicaid is that it is a selective welfare program for persons of very limited means and it is restricted to several categorical groups — poor families with children, the poor disabled and the poor elderly. Medicaid utilizes shared federal (national) and state resources. As states have limited resources and are often unwilling or unable to increase taxes,

funds for Medicaid are threatened just as the number of vulnerable older persons requiring medical assistance is increasing.

Examining Expenditure Patterns

In 1999, about $250 billion (or 23.6 percent) of national personal health expenditures of over $1 trillion were spent on long-term care related items (Cowan, et al., 2001). Such long-term care includes health, personal care and other supportive services. This figure based on national health expenditure data is very conservative as it has not factored in meals-on-wheels, adult day care and senior center programs used by the frail elderly and other senior citizens. (It is limited to an estimate related to health services, such as — home health, drugs and other non-durables, vision products and medical durables and other personal care services.) A more inclusive figure estimating the cost of other social services might result in a figure of public sector costs for long-term care of over $300 billion. Assuming that long-term care related expenditures were $250 billion in 1999, Medicaid nursing home care expenditures were $42.4 billion or 17 percent of such long-term care related spending (Cowan, et al., 2001). Home health expenditures under Medicaid in 1999 were $8.7 billion and under Medicare were $5.6 billion. Total home health expenditures of $14.3 billion under Medicare and Medicaid amounted to 1.4 percent of national personal health expenditures of over $1 trillion (Cowan, et al., 2001). Home health care amounted to 5 percent of total personal health care expenditures under Medicare and 3 percent of total personal health expenditures under Medicaid. However the Medicaid category of "other personal care" (a category not found in Medicare) constituted almost 12.2 percent of such Medicaid spending (Cowan, et al., 2001). Thus clearly, public spending for long-term care services goes heavily for institutional rather than in-home and community-based services.

Nevertheless, home care and community-based services in the United States are substantial. In 1994 about 15,000 providers delivered home care services to 7 million people who required such services due to acute illness, long-term health conditions, permanent disability and terminal illnesses. These included 7,521 Medicare Certified Home Health Agencies, 1,459 Medicare Certified Hospices and 6,047 Home Health Agencies, home care aid organizations and hospices that do not participate in Medicare. The cost of such care was over $23 billion (National Association for Home Care, 1995). By the year 2000, more than 20,000 providers were delivering home care services to 7.6 million persons requiring such services due to acute illness, chronic health conditions, permanent disabilities or terminal illness. Expenditures for such home health care were projected as $41.3 billion in 2001 (National Association for Home Care, 2001). As of March 2002, the number of Medicare Certified Home Health Care Agencies has fallen to 6,900 and the number of Medicare Certified Hospices had increased to 2,286 (Centers for Medicare & Medicaid Services, 2002).

An additional development in the area of long-term care services for the elderly in the United States has been the development of assisted living facilities. Such facilities generally operate without federal standards. U. S. health officials inspect only the few assisted living facilities which accept Medicaid funds. Even in these circumstances, federal officials typically inspect these facilities only once every three to five years.

Virtually all assisted living facilities hand out prescription drugs to residents who can no longer be depended on to remember to take their medications. Unlike nursing homes, assisted living facilities usually use uncertified aides, rather than licensed registered nurses or visiting nurses to distribute medications. In a survey of assisted living care conducted in the fall of 2000 by the National Academy of State Health Policy (a non-profit organization) state regulators in 46 percent of states responding replied that medication problems occurred "frequently to very often" (Mollica, 2001).

Generally, assisted living residents need help with one activity of daily living while nursing home residents require assistance with three basic activities. Nevertheless at an average age of 84 for women and 82 for men, assisted living residents find that their conditions eventually deteriorate even if they were relatively healthy on arrival. Industry figures suggest that half of all residents have symptoms of mental decline and a survey by the federal National Nursing Home Survey of 1995 indicated that one in four residents needs as much help with daily activities as the typical nursing home patient (Dey, 1997; Goldstein, 2001).

The PACE Program

One innovative approach undertaken in recent years is the Program for All-Inclusive Care for the Elderly (the PACE program). This program is innovative in its use of a mix of Medicare and Medicaid funds to provide a range of care services — including elder housing, as well as a number of community-based alternatives to institutional nursing home care. The program also makes use of gerontological teams including social workers, nurses, occupational and physical therapists, and nutritionists, as well as physicians in making assessment and service delivery decisions.

Initially, the PACE Program was instituted in the Chinatown area of San Francisco as the On Lok-PACE program (Bould, Sanborn, & Reif, 1989). On Lok is a consolidated care organization for dependent adults (CCODA) and primarily for the frail elderly. It is specifically designed for individuals requiring long-term care. It was specifically designed in 1973 by On Lok Senior Health Services, an organization serving nursing home - eligible elderly in an area of San Francisco where the residents were primarily of Chinese and Filipino ancestry. Participants in the On Lok program are provided a full spectrum of services ranging from acute to long-term care. Among, the services offered are sheltered housing for its participants.

A single monthly fee paid in advance covers all service costs a person may require including hospital and nursing home care. In the On Lok program , Medicare (the federal health insurance program mainly for the elderly) funds were joined with Medicaid (a federal /state program) funds for a targeted group who were eligible for this means tested program and considered to be in need of nursing home care. Instead of nursing home care, when professional assessment deems it possible, these individuals were provided with extensive community-based services.

The community-based PACE program assumes all risks of providing health care and related social services for members by capitated funding. Its goal is to demonstrate that careful management of the individual' s care plan and the program's financial resources will both enable the frail elderly to remain at home longer and will save public funds. Initially, the federal PACE legislation permitting the merging of the two funding streams and the institution of capitated funding in 1973. Subsequent legislation passed in 1986 called for 10 demonstration projects. PACE was made permanent by the Budget Reconciliation Act of 1997 and the number of PACE programs have since been developed. A study of the 10 initial PACE organizations found that in the 12 months following enrollment, the Medicare capitation rate for PACE was 42 percent lower than the projected Medicare payments in the absence of PACE (White, Abel & Kidder, 2000).

In 1999, 24 PACE sites were in operation. These sites assumed complete financial risk for the health care costs of their participants and were all were funded with pooled capitation funds from Medicare and Medicaid (Bodenheimer, 1999). Another set of 8 sites similar to PACE were funded by Medicaid capitation revenue and Medicare fees-for-service (Bodenheimer, 1999). These programs are all run by nonprofit organizations. About 6000 frail elderly are enrolled in these 32 locations. While serving a limited proportion of the frail elderly, PACE and PACE-like programs offer a "continuum of care" model which is appropriate for long-term care for the frail elderly. By October, 2000 an additional PACE site had been developed and other sites were in the process of development (National PACE Association, 2000).

Community-Based Care and Section 1115 Waivers

It is very difficult to reduce the institutional costs of long-term care. However, a 1994 U.S. General Accounting Office report focused on three states that have made substantial attempts to shift long-term care to community-based programs. The goal of these programs overall was to serve more beneficiaries and to provide services for a larger proportion of the frail elderly in their home communities. These particular demonstration programs (Section 1115 Medicaid-Waiver programs) took place in the states of Oregon, Washington and Wisconsin. Programs between each state varied as did programs within states. State and local program administrators exhibited some variations in their approaches (U.S. General Accounting Office, 1994). For instance, in Oregon and Washington, local administrators took various approaches to limiting demand ; these approaches ranged from first come, first

served waiting lists for eligible beneficiaries to priority ranking based on assessed beneficiary needs.

All three states developed approaches for controlling payments for home and community - based services. Regulatory controls utilized included: provider fee schedules and "capped" individual service budgets. Rates for services might vary according to the beneficiary benefit levels. All three states imposed per-beneficiary limits on hours of service or dollar benefits. Also, all of the states programs viewed case management as an important component of home and community-based services. Case managers typically assess beneficiary needs, determine financial eligibility, develop and monitor care plans, authorize social and health related services, and assist in securing needed services (Moore, 1992; Vourelekis and Greene, 1991).

The General Accounting Office report notes that Oregon's Nurse Delegation Act stands out nationally in its permitting nurses under contract with that state to train and monitor persons who are not licensed health care providers to perform certain specified medical services, i.e., administering medications (1994). Oregon officials believe that this use of non-professional caregivers makes the delivery of home and community-based care less costly, without undermining quality of care.

The three states reviewed were able to develop a more balanced infrastructure of community-based services vis-a-vis nursing home care services. While the number of nursing home facility beds operated in the United States increased by 20.5 percent between 1982 and 1992, the combined number of such beds in Oregon, Washington, and Wisconsin declined by 13 percent. In these three states, most of the growth in long-term care was achieved by increased home and community-based services (U.S. General Accounting Office, 1994). This growth allowed for a more balanced development between nursing home care and in-home and community-based services.

Appropriateness and Cost Benefit Analysis as Issues

An important and difficult issue for consideration in the United States (and other nations) is the determination of the extent "appropriate" home and community-based services for the frail elderly should be developed in instances when they may not appear to be the most efficient cost/benefits in service delivery. (By appropriateness, we refer to the delivery of services in a manner which has as its major emphasis the consideration of the physical, social and psychological needs of the frail elderly and which also emphasizes, in the design of services an understanding of the needs of family members and others who constitute the natural support system of the frail elderly. By cost /benefit analysis, one places a value — usually a monetized one — both as to program costs and program outcomes. While sometimes cost effectiveness analysis is confused with cost/benefit analysis,such cost effectiveness analysis only considers the costs of the program itself [Grinnell, Jr., 1996, p.574-575].) To state the issue another way:

(a) Home and community-based care may be clearly the most appropriate and produce the most efficient cost/benefits.

(b) Home and community-based care may be the most appropriate service from the viewpoint of the frail elderly and the involved family, but may not clearly produce the most efficient cost/benefits in the delivery of service;

(c) Home and community-based services may be neither the most appropriate or productive of the most efficient cost/benefits in the delivery of services.

In the first instance, support for home and community-based care is clearly desirous from the viewpoint of public policy. In the second instance (case b) humanitarian versus efficiency (at least short-run efficiency) arguments will clash in the debate over the direction of public policy to be adopted with regard to an emphasis on institutional vis-a-vis home and community-based services. This paper argues that in case b appropriateness in terms of both patient and family needs (and it is argued desireable public policy) should be considered the paramount policy consideration. By cost/benefit assessment we refer to a form of analysis which seeks to determine the mode of delivering services which provides the greatest benefits for the least cost (Grinnell, Jr., 1997; Levine, 1978; Wilensky, 1997.)

From the viewpoint of the frail elderly, too exclusive an emphasis on institutional care is unfortunate. The elderly, in the United States, wish to remain inde-

pendent for as long as possible and turn to family, friends or often to community-based options (e.g., boarding homes) if they become functionally limited. A comparison of institutionalized and non-institutionalized elderly has shown that those in nursing homes are generally those persons who have limited family resources and/or the most severely disabled group (Palley & Oktay, 1989, 1991). A number of studies suggest that home care services and supportive community-based services can prevent the development of a need for a significant amount of institutional services (Bould, Sanborn & Reif, 1989; Palley and Oktay, 1989). There are some indications that home-based care may successfully rehabilitate many of those elderly who suffer from a moderate chronic disability. It also may serve to prevent rapid deterioration of some patient conditions.

However, study findings are inconclusive regarding overall cost savings or decreased rates of institutionalization where community-based services are available. The problem with some cost-based studies is that they are currently examining very inefficient health system organizations. Thus, research findings unrelated to system reform lack validity. What is clear, however, is that community-based systems can be successful in helping the frail elderly avoid unwanted institutionalization (Bould, Sanborn & Reif, 1989, pp.188-189; Palley and Oktay, 1989, 1991).

A U.S. General Accounting Office study has indicated that home care is less expensive than institutional care at mild or moderate disability levels, if family support is provided (Palley and Oktay, 1989; U.S. General Accounting Office, 1982). However, for cases of severe disability, nursing home costs are lower than home health and social service costs if costs to the family are computed as a cost of care (Palley & Oktay, 1989).

In cases where appropriateness and cost/benefit considerations are clearly congruent, hard choices regarding public policy need not be made. The difficult public policy choices are found where humane ethics and quality of life considerations indicate the desirability of home and community-based service development when, at least in the short run, institutional service development would appear to be more efficient in terms of cost/benefits. However, an analysis of the federally-supported Channeling Demonstrations which examined in-home and community-based care while questioning the cost-effectiveness of such care concluded with a recognition of the importance of the public policy goal of appropriateness. It concluded: "... expansion of community care must be justified not in its cost savings but on its (unmeasured) benefits to the disabled elderly and the family and friends who care for them" (Kemper, et al., 1987, p.97). Such benefits include a sense of well-being and an improved quality of life for the disabled elderly and family care givers. Moreover, some social scientists have questioned the objectivity and suggested political bias in the valuations attributed to some cost/benefit approaches (Wildavsky, 1979; Wilensky, 1983, 1997).

Conclusion

A central consideration in public policy decisions regarding long-term care for the frail elderly is the issue of appropriateness with respect to the needs and desires of this group of citizens. It is important to indicate the need to consider the views of the elderly and their families regarding their service needs, as well as the need to collect and analyze relevant demographic data and to refine the measurement of disability, in order to determine as precisely as possible the appropriateness of services for the frail elderly. At times — indeed frequently, the goal of appropriateness is congruent with a cost/benefit approach and with cost-effectiveness. There is clearly a congruence between home and community-based care for a less severely disabled stratum of the frail elderly and a congruence between appropriateness and cost/benefit analysis for nursing home care for the very severely disabled elderly.

At other times, the normative goal of providing appropriate home and community-based care in "a least restrictive environment" may appear to clash with immediate (or perceived short-term) cost/benefit and cost-effectiveness considerations in the development of long-term care policy. This conflict may in actuality be more apparent than real as the "high costs" are often the result of an inefficient and poorly organized health and social system in the United States. Nevertheless, in a society, in which both conservatives and social progressives value the maintenance of personal freedom, the preferences of the aged and their

families as well as quality of life considerations represent a significant imperative for developing a more coherent policy emphasizing "a continuum of care" and a full range of services regarding the care of the frail elderly. Despite conflicting budgetary claims on scarce resources, the evolution of a long-term care policy for the elderly which seeks to emphasize the maintenance of a desirable quality of life in a "least restrictive setting" should be an overriding normative goal. At the same time such a policy should not unduly burden family caregivers. Also, this approach recognizes the circumstances in which institutional care is appropriate. The experience of the Scandinavian nations and, more recently, Japan in different ways have shown that "appropriateness" as a policy goal is feasible (Palley & Usui, 1995; Sundstrom, 1985; Talbert, 1999; Usui & Palley, 1997).

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講演要旨

「アメリカの高齢者介護」21世紀におけるケアの展望を構築する

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本講演は，アメリカ合衆国の高齢者の長期ケア政策を課題とし，公共支出とコミュニティケア，および在宅ケアの開発に主眼を置いてケア政策の展望を示すことを目的としている。

2000年には，合衆国の人口（281,422,000人）の12.4%が65歳以上となり，65～74歳は人口の6.5%，75歳以上は約6%を占めている。

長期ケアは，個人の能力に発生した障害によって日常生活の維持に困難が生じた場合，または，回復の見込みが少ない慢性化した疾病などのために必要となる。長期ケアには，社会サービスによるケア，および保健医療ケアの双方が含まれる。

コミュニティケアの必要性が論議されているのにもかかわらず，合衆国における公的な長期ケアサービスは施設ケアが中心である。それは，主に老人ホームにおけるケアを指し，ミーンズテストを行うメディケードプログラムを通じて供給される。

1995年の全国老人ホーム調査によると，老人ホームの入居者の75%が女性である。また，82%が75歳以上であり，92%がヒスパニック系でない白人によって占められている。入所時の平均年齢は82歳であり，38%がメディケイドプログラムでミーンズテストを受けて入所している。

1999年には長期ケアにかかわる個人保健費支出の約半数が高齢者および彼らの家族によって負担されている。メディケイドは公費によってまかなわれており，財源に制限があるので，障害を持つ高齢者数が増加しているため，資金繰りが苦しくなっている。

1999年には，保健ケア，社会サービス，その他の補助サービスを含む長期ケア関係の支出額は2500億ドル（全保健費の23.6%）といわれており，そのうちの17%がメディケイドによる老人ホームケアであり，施設ケアに重点が置かれている。

しかしながら，合衆国では，ホームケアおよびコミュニティを基盤とするサービスも重要である。1994年には約15,000人の提供者（メディケア認定のホームヘルスエージェンシー，ホスピス，メディケアに所属しないその他のホームヘルプ業者，団体，ホスピス等）が，急性，慢性，末期の疾病や障害のために，このようなサービスが必要となった700万人を対象としてサービスの提供を行った。これらのケアのコストは230億ドル以上になる。2000年までにはケア提供者は2万人以上，受給者は760万人になり，2001年の支出は413億ドルになると見込まれている。

また，高齢者の長期ケアサービスの傾向として，サポートつきの住居施設の開発が挙げられる。これらの施設は連邦基準外で運営されており，保健当局はこれらの施設の検査をほとんど行っていないのが一般的である。しかし，これらの施設の多くが，老人ホームで採用されているような有資格のナースを採用していないにもかかわらず，処方薬を健忘症のある入居者に渡している。2000年秋におこなわれたサポート付の住居施設についての調査では，回答した州の46%が，かなりの頻度で投薬問題が発生していることが報告されている。

一般にサポート付住宅の入居者の方が，老人ホーム入居者よりもケアの必要度が低いとされている。しかし，女性が84歳，男性が82歳という平均入居者年齢と痴呆症の発病を考慮すると，入居時には比較的元気な入居者も，4人に一人は老人ホームとかわらないケアが必要となってきている。

PACEプログラム（Program for All-Inclusive Care for the Elderly）は，メディケアとメディケイド基金をミックスして高齢者住宅，施設ケアに代わるコミュニティケアなどを含むケアサービスを提供するために近年作成された。このプログラムでは，ソーシャルワーカー，看護士，OT・PT，栄養士，医師を含む老人学のチームを，ケアの評価を行いサービスプランを作成するために活用している。

長期ケアにかかわる施設コストを軽減することは容易ではないが，1994年に合衆国一般会計局の報告書は，長期ケアをコミュニティベースのプログラムに変換するための根本的な試みを行ったオレゴン，ワシントン，ウィスコンシンの3つの州に焦点を当てている。このプログラムはSection 1115 Medicaid-Waiver programsと呼ば

れる。プログラムでは，ホームサービスおよびコミュニティベースのサービスの料金を管理する方法の開発が試みられている。たとえば，オレゴン州では，州と契約を結んだ看護士に，有資格でないケア提供者にある程度の限られた医療サービスを行えるように指導することを可能にする法律が存在する。

これら3つの州では，コミュニティベースのサービスと老人ホームケアサービスのよりバランスの取れたインフラを開発することが可能であった。1982年から1992年の間に，合衆国全体では老人ホームのベッド数が20.5%上昇したのにもかかわらず，オレゴン，ワシントン，ウィスコンシンの3州では13%減少している。これらの州では，長期ケアをホームケアおよびコミュニティベースのケアを増加させることによって行っている。

高齢者にとっては，施設ケアが重視され過ぎることは不幸なことである。というのは，合衆国の高齢者はできるだけ自立して生活し，心身の機能が低下するようになったら，家族や友人などコミュニティベースのサポートを望んでいるからである。施設に入居している高齢者とそうでない高齢者とを比較すると，施設入居者のほうに家族がなく，障害の度合いが強い人が多いことが一般的な傾向と見られる。

多くの研究が，ホームケアサービスおよびコミュニティベースのサービスを充実すれば，施設ケアの開発をかなりの程度抑制することが可能であることを提言している。また，ホームケアは慢性的な障害を持つ高齢者のリハビリに成果を上げており，症状の悪化を防ぐ役割を果たしているとの報告もある。ただし，コミュニティベースのサービスが利用できれば，施設化のコストを軽減できるという結論を導きだすような研究結果は報告されていない。

合衆国の一般会計局の研究によれば，ホームケアは，障害の度合いが低く，家族のサポートが提供される場合には施設ケアよりも安価であるが，重度の障害の場合は，家族の負担をケア負担として計算すれば，施設ケアのほうが安価になる。適正さと負担・利益計算が明白に一致するときには公共政策において困難な選択をする必要はない。困難な選択とは，ホームケアおよびコミュニティベースのサービスのほうが人間的であり，生活の質の観点からよりよいものであると考えられるにもかかわらず，少なくとも短期的な展望においては，施設ケアサービスのほうが負担・利益計算において勝っている場合に行わねばならない選択である。

高齢者のための長期ケアに関する公共政策の決定にかかわる中心的な考え方は，相当する市民グループのニーズと願望に敬意を払いつつ，適正さを図ることにある。虚弱な高齢者のために，できるだけ正確かつ適切なサービスを決定するにあたっては，サービスのニーズについての高齢者や彼らの家族の意見を考慮する必要性，適切な人口学的データを収集し分析し，障害の測定をより正確に行う必要性があることを指し示すことが重要である。

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